## INTRODUCTION

The Commonwealth of Massachusetts continues to demonstrate a strong commitment to significantly increase the number of youth who abstain from sexual activity, delay the onset of sexual activity and decrease the number of adolescent births through the provision of a statewide abstinence only school-based program. The assigned lead agency is the Department of Public Health (DPH). DPH, through a competitive procurement, contracted with A Woman's Concern's Healthy Futures Program (Healthy Futures) to provide the school based abstinence education. Healthy Futures, a CBAE grantee, has extensive experience in two of the six regions of the state and will subcontract out to the other four regions to ensure this is a statewide program reaching youth ages 12 – 14 and their families.

The primary goal of the Massachusetts Abstinence Education Program is to significantly increase the number and percentage of youth that remain abstinent outside of marriage. The four objectives are to:

1. Increase self-esteem, pride and a sense of future self-sufficiency in adolescents;
2. Increase youth's ability to avoid peer pressure, unhealthy and abusive relationships;
3. Educate youth about the association between alcohol and other substances in relationship to sexual assault and the ability to remain abstinent; and,
4. Support parents to instill positive values and set clear limits and behavioral expectations for their children.

For Fiscal Year 2007, the program will provide abstinence-only education in schools for youth ages 12 – 14 and their families, stressing the importance of family involvement to reinforce the abstinence message. Continued emphasis will be placed in

the Hispanic and Black communities, where higher rates of sexual activities and higher teen birth rates are consistently reported.

Furthermore, youth with disabilities and their parents/caretakers will continue to serve as a subset target population within schools both for programs and for specifically designed education materials. The project will continue to highlight issues of sexual abuse and exploitation for this population.

## PROGRAM PROPOSAL NARRATIVE

### IV.1 DESCRIPTION OF PROBLEM AND NEED

The Massachusetts teen birth rate declined by 37% from 1990-2004. In general, Massachusetts enjoys a significantly lower overall teen birth rate compared to the United States: the overall Massachusetts adolescent birth rate for 2004 was 22.2 births per thousand for women ages 15-19, compared to the national rate of 41.2. Teen birth rates among all race and ethnic groups in Massachusetts have declined over the past decade.

In 2004, of all live births to Massachusetts resident teens, 46.7% (2,128) were to White non-Hispanic mothers; 32.9% (1,499) were to Hispanic mothers; 13.0% (591) were to Black non-Hispanic mothers; 3.3% (152) were to Asian mothers; and 4.0% (184) were to Other mothers. Yet, Hispanic teens represent approximately 10% of the overall population, and Black non-Hispanic teens approximately 7%, thus they are significantly over-represented in these data. Further, while great strides have been made in decreasing the teen birth rate among all race and ethnic groups, there has not been uniform success. Black non-Hispanic teens have had the greatest decrease in birth rates, 50% from 1994 (87.6) to 2004 (43.6); the Asian teen birth rate decreased by 47% (from 27.3 to 14.5); the

Hispanic teen birth rate decreased by 45% (from 138.8 to 75.7) while the White non-Hispanic teen birth rate declined the least at 34% (from 20.1 to 13.2). Historically, teen births have been highest for the Hispanic population, followed by Black non-Hispanic, White non-Hispanic, and Asian. Massachusetts' communities with the highest teen births are mostly comprised with populations of color, and continue to have significantly higher rates than the state average.

Data from the 2005 Massachusetts Youth Risk Behavior Survey[2] indicate that among adolescents who were sexually active, the highest reported sexual activity was among Black (64.8%), followed by Hispanic (58.5%) and White (42.3%). These data indicate that it is imperative to reduce disparity among teen births and teen risk-taking behavior. The 2005 Massachusetts Youth Risk Behavior Survey reported that 45% of youth surveyed reported having sexual intercourse during their lifetime. About 5% of adolescents reported initiating sex before age 13, a decrease from 8% since 1995.

The 2003 Massachusetts Youth Risk Behavior Survey reported that about 6% of adolescents reported initiating sex before age 13. Students who had sexual intercourse in the three months preceding the survey were significantly more likely than students who were not sexually active to report current alcohol use (67% vs. 36%), experiencing sexual contact against their will (18% vs. 5%), and experiencing dating violence (21% vs. 5%). Sexually active students were significantly less likely to report receiving mostly passing grades than their counterpart (84% vs. 90%). Students who reported being sexually active in the past three months were less likely to report that there was a parent or other adult family member they could talk to about things that were important (29% vs. 34%),

less likely to have participated in volunteer or community work (25% vs. 33%, and less likely to have participated in organized extra-curricular activities (24% vs. 36%).

In Massachusetts in 2005, the Chlamydia rate for 15-19 year olds was 1,114.4 per 100,000 and the gonorrhea rate was 137 per 100,000 for the same age group. These rates are lower than the U.S. rates of 1,578.5 per 100,000 for Chlamydia and 427.1 per 100,000 for gonorrhea.

In 2003, among interviewed parents with 13-17 yr old children in their household through the Behavioral Risk Factor Survey, the large majority (79.5%) reported having ongoing and frequent communication (at least every few months) with their teens about sexual issues. While this percentage remains high, there is some cause for concern. This proportion grew steadily from 1998 to 2002 (74.6 to 83.3), but now shows a decline to 79.5 in 2003, indicating a need for renewed efforts to educate parents about the importance of communicating with their teens about the risks of early sexual activity.

In 2003, 24.5% of MA high school youth (grades 9-12) reported having had a conversation with a family adult about sexual issues at least once every few months, showing little change since 2001 (24.0%), and down slightly from 26% in 1999. This percentage is in striking contrast to the percentage of parents in the 2003 BRFS who reported having had a conversation with their teenager at least every few months (79.5%). This disparity is consistent with other study findings comparing parent and teen reports of the frequency of communication about sexual issues.[1,2]

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[1] Jaccard, J., P. J. Dittus, et al. (1998). Parent-adolescent congruency in reports of adolescent sexual behavior and in communications about sexual behavior. Child Development **69(1):** 247-261.

[2] Massachusetts Youth Risk Behavior Survey Executive Summary 2005. Final report not yet available.

[2] King, B.M., Lorusso, J. (1997) Discussions in the home about sex: Different recollections by parents and children. Journal of Sex & Marital Therapy **23**: 52-60.

## IV.2 FOCAL POPULATION AND PRIORITY NEEDS

*Groups with Greatest Needs* - Youth between the ages of 12 – 14 years are the group with the greatest need based on the data below that show that this is a crucial time in the development of risk taking behaviors. The National Campaign to Prevent Teen Pregnancy reports[3]:

- 81% of 12 – 14 year olds who have had sex wish they had waited;
- Approximately 1 in 5 adolescents have had sex before his/her 15th birthday;
- Most of those adolescents aged 14 and younger who have had sex are not currently sexually active;
- Approximately 1 in 7 sexually experienced 14 year old girls reported having been pregnant;
- 1 in 10 girls who have had sex before age 15 reported it was non-voluntary and many more describe it as relatively unwanted;
- Girls who first had sex at age 14 or younger had more sexual partners as a teenager on average than girls who first had sex at age 15 or older;
- Young teens seem to have the opportunity to have sex;
- Half of those aged 12 -14 report having been on a date or having a romantic relationship in the past 18 months; and,
- Sexually experienced teens were more likely than virgins to engage in other risky behaviors such as smoking, illegal drug use, and drinking once a week or more.

In addition based on the data described in Section IV.1. populations of color in Massachusetts, particularly Black and Hispanic, are at higher risk of sexual activity and

[3] *14 & Younger: The Sexual Behavior of Young Adolescents.* The National Campaign to Prevent Teen Pregnancy PowerPoint Presentation. May 2003.

births to teens than White. The communities with the teen birth rates higher than the state average are located in all 6 regions of the state. Furthermore, youth with disabilities are a high-risk population deserving particular attention. Parents/caretakers of high risk youth will continue to serve as a subset target population within schools both for programs and for specifically designed education materials.

*Existing Programs* - The two community agencies who are awaiting notification from ACF regarding continuation of their CBAE grants are A Woman's Concern's Healthy Futures Program and Catholic Social Services of Fall River. These two programs have been the lead agencies in Abstinence education in the state. Healthy Futures was awarded the subcontract for the Title V Program and began a contract June 1, 2006.

*Gaps in Services* - Neither of the two CBAE grantees have programs in all 6 regions of the state leaving Western Massachusetts, Central Massachusetts, and MetroWest without abstinence education in the schools. And the program services available in the other regions are centralized in specific areas of the state that are close in proximity to the location of the two providers above. As a result many communities are left without the option for abstinence-only education.

*Focal Populations* - Massachusetts will continue to provide abstinence education in schools for youth ages 12 – 14 and their families, stressing the importance of family involvement to reinforce the abstinence messages. These youth will be in geographic communities with the highest teen birth rates. Continued emphasis will be placed in Hispanic and Black communities where there are higher rates of sexual activity and birth rates. One community from each region of the state will be represented to thus serve as a resource for other communities within the region.

*Priority Needs* -

1. Increase self-esteem, pride and a sense of future self-sufficiency in adolescents (ages 12-14);
2. Increase youth's ability to avoid peer pressure, unhealthy and abusive relationships;
3. Educate youth about the association between alcohol and other substances in relationship to sexual assault and the ability to remain abstinent; and,
4. Support parents to instill positive values and set clear limits and behavioral expectations for their children.

**IV.3 Overall Plan** (using the format suggested in federal guidance)

| Activity: In-class instruction for 12-14 year olds in one middle school in each of 6 regions of state. | | | | |
|---|---|---|---|---|
| Program Goal addressed: 1 | | | | |
| Mechanism Used: Contract with Healthy Futures to conduct work in 2 regions (Boston and Northeast) and competitively procure sub-contracts in other 4 regions. | | | | |
| Broad Steps to Accomplish: | | | | |
| **Step** | **Responsible Party** | **Expected Output** | **Start Date** | **End Date** |
| Work with Healthy Futures to agree on curriculum to be used | State Coordinator, Healthy Futures staff | Curriculum finalized | 10/06 | 11/06 |
| Provide technical assistance to design RFRs and to competitively bid subcontracts | State Coordinator, Healthy Futures staff | RFR finalized and subcontracts chosen | 7/06 | 12/06 |
| Train curriculum educators | Healthy Futures staff | Educators trained | 7/06 | 11/06 |
| Develop relationships with desired schools/districts | Healthy Futures with DPH staff as needed, School personnel | Agreements with schools finalized | 6/06 | 5/07 |
| Implement curriculum | Healthy Futures staff and School Personnel | Students received 5 hours | 9/06 | 6/07 |
| Activity: Peer Education | | | | |
| Program Goal addressed: 2 | | | | |
| Mechanism Used: Contract with Healthy Futures to conduct this work | | | | |

| Broad Steps to Accomplish: | | | | |
|---|---|---|---|---|
| **Step** | **Responsible Party** | **Expected Output** | **Start Date** | **End Date** |
| Provide an 8 week summer program to train youth as peer educators | Healthy Futures staff | First part of training completed as a peer educator | 6/06 | 8/06 |
| All youth who complete summer program serve for 1 year as a volunteer teen intern and receive mentoring | Healthy Futures staff and peer leaders | Second part of training completed as a peer educator | 9/06 | 6/07 |
| Peer educators become assistant teachers for the new class of peer educators and assist in training other teens | Healthy Futures staff and peer leaders (old class and new class) | Youth are fully trained as peer educators and are ready to go into the classrooms | 6/07 | 8/07 |
| Peer educators teach teens in the classroom and mentor teen interns | Peer educators and teen interns | Peer leaders use their new skills and peer leaders-in-training are trained | 9/07 | 6/08 |
| Activity: Provide virtual classroom education through an interactive website | | | | |
| Program Goal addressed: 3 | | | | |
| Mechanism Used: Contract with Healthy Futures to conduct this work | | | | |
| Broad Steps to Accomplish: | | | | |
| **Step** | **Responsible Party** | **Expected Output** | **Start Date** | **End Date** |
| Develop website content for 6th grade students | Healthy Futures staff and web site developer | Website | 6/06 | 10/06 |
| Develop promotional materials for the website | Healthy Futures staff and materials designer | Promotional materials developed | 8/06 | 11/06 |
| Promote the website for all youth | Healthy Futures staff and peer leaders | Use of website will enhance youth understanding of abstinence | 11/06 | 9/07 |
| Activity: To encourage parent child communication about sexuality | | | | |
| Program Goal addressed: 4 | | | | |
| Mechanism Used: Contract with Healthy Futures to conduct this work | | | | |
| Broad Steps to Accomplish: | | | | |
| **Step** | **Responsible Party** | **Expected Output** | **Start Date** | **End Date** |
| Give all youth who participate in | Healthy futures staff and youth | Parents receive booklet on tips for | 9/06 | 9/07 |

| | | | | |
|---|---|---|---|---|
| Abstinence curriculum a 16-page booklet for their parents | | talking with your child | | |
| Abstinence curriculum has activities that students take home and complete with their parents requiring youth to initiate conversations | Healthy Futures staff | Youth are given skills for having difficult conversations with their parents | 9/06 | 9/07 |
| Provide parent sessions at schools or in communities in conjunction with school programs | Healthy Futures staff | Parents are offered the opportunity to strengthen their skills for having difficult conversations with their kids | 9/06 | 9/07 |

While Massachusetts has the primary goal of significantly increasing the number and percentage of youth that remain abstinent outside of marriage, the program goals through the work of Healthy Futures' Abstinence Education in the Schools Program, which are referenced numerically in the table above are:

1. Annually provide abstinence-until-marriage education to youth 12-14 in at least one school in each of the 6 regions of the state.
2. Train youth to be peer leaders and serve as mentors and educators to younger youth
3. Enhance school based programming by providing virtual learning via an interactive website designed for youth. In addition, a number of materials were designed to supplement the abstinence education-only message in the schools. While distribution of these abstinence-only educational materials will occur in school, they will also be made available to communities statewide.

4. Strengthen parents' and youths' capacity to talk about sexuality in the family. Materials also designed for parents to strengthen the abstinence-only message will be distributed.

*Response to Cultural Characteristics* – The state procured Abstinence Education services from Healthy Futures using a competitive RFR stated that the vendor must have a demonstrated commitment to cultural competence. Healthy Futures positions descriptions ensure culturally competent programming including knowledge of primary languages of target population. Parent materials will be translated into appropriate languages of its program recipients including Spanish, Khmer and Haitian Creole.

*Barriers*: DPH and its vendor, Healthy Futures, anticipate the following barriers: 1) skepticism from decision-makers in the schools about the effectiveness of abstinence education as a means of reducing teen sexual activity, 2) disbelief that teens can actually make and sustain the choice to wait until marriage , and 3) many youth find it difficult to visualize a healthy-long-lasting marriage relationship of their own, largely due to lack of models of such relationships in their home, community or the media. The role of Healthy Futures is to develop relationships with a wide array of community partners and educate them on the benefit of this program. The staff do this by providing key stakeholders and decision-makers the opportunity to observe the abstinence program. In addition Healthy Futures is committed to helping youth understand the importance of marriage and fatherhood within the structure of the family and society and to learn about the benefits such relationships provide to individuals, families and society.

*Referrals:* All contractors of the Massachusetts Department of Public Health are required to provide meaningful referrals to the youth in the programs. These referrals include but

are not limited to key school personnel including school nurses and counselors, youth development agencies, primary care providers including school based health centers where appropriate, mental health providers, Rape Crisis Centers, family planning agencies, suicide prevention hotlines and providers, GLBT networks for youth and families.

*Grantee Meeting:* The State Project Coordinator or the Director of the Office of Adolescent Health and Youth Development plan to attend the grantee meeting scheduled for December 6-8, 2006.

**IV.4 EVALUTATION**

Through a Request for Responses, MDPH will seek a qualified program evaluator to design and implement a formative, process, and outcomes evaluation of the school-based program. The program evaluator will be responsible for the development of an evaluation plan and data collections tools, implementation of evaluation activities, data entry, cleaning, and analysis, and written reports with conclusions and recommendations. Based on the program goals outlined in the Overall Plan, the objective performance measures are noted below.

*Objective Performance Measures*

1. Output measure: By June 30, 2009, 9,000 middle school students in high risk communities in all 6 regions of the state will successfully complete or remain enrolled in a school-based abstinence education program. The baseline measure is 1,500 youth in 4 regions for FY07. In FY08 an additional 4,000 in 6 regions of

the state. The state will collect and analyze this data based on annual reports submitted by Healthy Futures.

2. Outcome measure: By June 30, 2009, 70% of program participants will report recently (in the last few months) having had a conversation with their parent(s)/guardian(s) about sexual issues. The baseline measure is 50% of program participants in FY07, 60% in FY08, culminating in 70% in FY09. The state will collect and analyze this data based on participant evaluation results submitted annually by Healthy Futures.

*Objective Efficiency Measures*

- ◊ Unduplicated Count of Clients Served (Form A) – the state requests this data from the contracted agency, Healthy Futures, on a monthly basis.
- ◊ Hours of Service Received by Clients (Form B) – the state requests this data from the contracted agency, Healthy Futures, on a monthly basis.
- ◊ Program Completion Data (Form C) – The state requests this data from the contracted agency, Healthy Futures on a monthly basis
- ◊ Communities Served (Form D) – The state requests this data from the contracted agency, Healthy Futures on a monthly basis.

In addition, it is important that the project continues to monitor the following measures instituted since the inception of the project to look at trends across sexual activities, STDs, and increased parental guidance and involvement, a key factor in helping adolescents to make healthy decisions.

**Goal 1: To reduce the proportion of adolescents 17 and younger who have engaged in sexual intercourse.**

Measure: The percent of high school age adolescents who have engaged in sexual intercourse during the reporting period. (Grades 9-12)

Objective: Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 39.5% for all youth in grades 9-12.

Data Source: Massachusetts Youth Risk Behavior Survey (YRBS)

**Goal 2: To reduce the incidence of STD's among adolescents.**

Measure: The rate of teenage youths, 15-19 years old who have contracted a bacterial STD, specifically Chlamydia or gonorrhea, during the reporting period.

Objective: Reduce the adolescent STD rates to 872 per 100,000 youth ages 15-19 for Chlamydia and 135 per 100,000 for gonorrhea.

Data Source: MDPH STD Program Surveillance System

**Goal 3: The percent of youth who reported having had a conversation with their parents or other adults in the family about sexual issues at least every few months.**

Measure: The percentage of youth that report a change in attitude, knowledge and beliefs.

Objective: To increase to 26% the percentage of youth in Massachusetts who report having had a conversation every few months with a parent or other family adult about sexual issues including STDs/HIV and pregnancy, prevention and abstinence.

Definition: Numerator: Number of high school youth reporting having at least one conversation about sexual issues with a parent or other family adult every

few months.

Denominator: Total number of youth surveyed.

Data Source: MA Youth Risk Behavior Survey

**Goal 4: To increase the percent of parent(s) who report having had a conversation with their child/children about sexual issues.**

Measure: The percentage of parents with children under age 17 who report a change in knowledge, attitude and beliefs consistent with the importance of adolescents remaining abstinent outside of marriage.

Definition: Numerator: Number of parents with children between the ages of 13 and 17 years who report a specific attitude or behavior of interest.

Denominator: Number of parents with children between the ages of 13-17 surveyed.

Data Source: Massachusetts Behavioral Risk Factor Survey (BRFS)

## IV.5 COORDINATION

*Partners* - The Massachusetts Department of Public Health emphasizes partnership with its constituency. Partners, particularly the community, have been and continue to be involved throughout the project.

- ◊ The formal partnership is with Healthy Futures, a program of A Woman's Concern, who is DPH's vendor for the Abstinence Education Program. This agency is also a CBAE grantee and has a wealth of experience providing these services in several communities. Healthy Futures is required by DPH to partner with the community and does so through a community advisory committee,

contact with parents of students in its programs, peer educator input and feedback, student evaluations, and focus groups with teens that help shape new programs as well as partnering with existing youth serving organizations.

◊ In recent years MDPH worked closely with the other CBAE grantee, Catholic Social Services of Fall River to focus group test abstinence education materials in various stages of development which are currently available for schools to use in their abstinence programs and incorporate recent data, researched publications and quotes from the targeted audience, including, but not limited, to youth and counselors, community advocacy groups, and organizations. These stand-alone and complementary materials were developed with the input from parents, pre-adolescents or "tweens" and adolescents.

◊ The evaluation of Healthy Future's school-based program will involve significant participation and input from the targeted audiences.

◊ In order to continue to meet the federal expectation for public input, community involvement, and collaboration with other programs throughout future project implementation, the Project Director will participate in a number of conferences, calls or meetings with other New England State Abstinence Coordinators, partake in statewide conferences, coordinate efforts with in-house staff and community organizations, and sit on a number of youth development related projects. They have and will include, but are not limited to:

- Abstinence Education Providers: school program leaders, youth program providers, faith-based program providers, health educators, and teen pregnancy prevention program providers.

- Parents and Youth (including youth with disabilities)
- Established youth policy groups (i.e., the Governor's Adolescent Health Council, Youth Violence Prevention Coalition).
- Medical providers and organizations such as the Academy of Pediatrics and Federation for Children with Special Health Care Needs.

**IV.6 CONSUMER INVOLVEMENT**

*Consumers Involved with Drafting the Application* - The continued inclusion of our constituency will ensure successful strategies for the future of the Massachusetts Abstinence Education Program. While consumers did not directly assist in the drafting of this application, the FY06 funding of Healthy Futures to conduct a school based abstinence program came about because of consumer feedback via the posting of past applications on the website and advocacy to state officials.

*Plan for Ongoing Consumer Involvement and Coordination* - Continued community involvement at the state level will be maintained for the duration of the grant period by posting this application on the Department's website to allow for comments from the general public. In addition, Healthy Futures, the state's vendor and CBAE grantee, will continue to engender ongoing consumer input and feedback through the various mechanisms described in section IV.5. This includes consumers among the populations to be served in the school based abstinence education program for youth and their families.

## IV.7 LEGISLATIVE PRIORITES

The Massachusetts' Abstinence Education Program continues to support priorities as defined by Congress. The program is intended to: increase awareness regarding the importance of abstaining from sexual activity outside of marriage for youth; encourage family and community support; and instill a sense of pride in youth who choose to remain abstinent. The Commonwealth understands the full intent of the legislation. In partnership with our vendor, Healthy Futures, and our constituency, we will continue to ensure that all program components, selected materials, and project activities do not conflict with any of the definitions. Attachment H-1 documents how the Healthy Futures program meaningfully represents each of the A-H elements.

## IV.8 ASSURANCES

*Proposed Program and Materials* – Massachusetts provides assurances that the proposed abstinence education program's curriculum and any additional materials do and will meaningfully represent each of the Section 510(b) (2) A-H elements and do not and will not promote contraception and/or condom use.